AUTHORIZATION FOR LIMITED RELEASE OF MEDICAL INFORMATION

This document is only used when an employee is incapacitated or unable to obtain medical documentation.

PRIVACY ACT STATEMENT

The information provided will be used primarily to facilitate the processing of your request for reasonable accommodation. Only the parties with a need to know will have access to this information to make an appropriate determination as to approval or denial of your request for accommodation. The information may be furnished to other authorizing officials who have a need for the information in the performance of their official duties. While disclosure is voluntary, failure to provide the requested information may unfavorably affect the disposition of your request. (42 U.S.C. § 12101 et seq.; 29 U.S.C. § 701 et seq.)

AUTHORIZATION REQUEST

The U.S. Department of Energy (DOE) requests authorization to obtain information from your physician, physical therapist, rehabilitation counselor, vocational counselor, or other appropriate healthcare provider, concerning your disability and/or functional limitations, as they pertain to the requirements of your current position or the position for which you are applying. Completion of this release is voluntary; however, without sufficiently acceptable medical documentation, your request for reasonable accommodation may be administratively closed.

Please complete the Employee Authorization section of this form, return the original signed copy to the Local Accommodation Coordinator (LRAC) identified below, and keep a copy for your records.

_____ _____

LRAC Name LRAC Phone No.

EMPLOYEE AUTHORIZATION

I hereby authorize the assigned DOE LRAC to contact the medical professionals I have listed below to obtain supporting information about my medical condition as it pertains to my request for reasonable accommodation, and to discuss any information with the medical professionals that is pertinent to my request for accommodation. I understand this may include:

- Confirmation that my medical condition is a disability under the Americans with Disabilities Amendments Act (ADAAA);
- Information as to the functional limitation(s) or work-related restrictions associated with the stated disability;
- Why the request for reasonable accommodation is needed; and
- Recommendations regarding accommodations.

I understand that it may be necessary to reveal to others with a need to know my identity and medical information; however, I also understand all information collected and discussed will be treated with confidentiality in accordance with applicable laws.

I understand that any non-genetic information, in compliance with the 2008 Genetic Information Nondiscrimination Act (GINA), gathered to process my request will be considered by DOE when making the decision to grant or deny my request.

This authorization applies to the following Healthcare Providers:

_____ _____

Healthcare Provider Name Healthcare Provider Phone No.

_____

Healthcare Provider Facility Address

_____ _____

Healthcare Provider Name Healthcare Provider Phone No.

_____

Healthcare Provider Facility Address

☐ I have read and understand the above notice. I authorize the DOE LRAC to request and receive medical information pertinent to my request for accommodation.

_____ _____

Employee Name Today's Date

_____

Employee Signature

This serves as record of the employee's reasonable accommodation. A copy of this will be retained by the LRAC, separate from the employee's Official Personnel File.